APPENDIX 5
INSTRUCTIONS FOR COMPLETING HCFA FORMS

The HCFA-485, Home Health Certification and Plan of Treatment, is the plan of care which must be completed for each Wisconsin Medicaid Medical Assistance Program (WMAP) home health and private duty nursing recipient. The HCFA-486, Medical Update and Patient Information, contains data which is often essential for determining the medical necessity of care ordered in the HCFA-485. The HCFA-487, Addendum to the Plan of Treatment/Medical Update and Patient Information, may be used to provide additional documentation of any elements on the HCFA 485/486.

These forms are national forms which are available from your Medicare carrier. For most WMAP providers, this is Blue Cross/Blue Shield United of Wisconsin. These forms are not available from EDS. When you complete these forms to provide information to Medicare for a client who is eligible for both Medicare and Medical Assistance, you may submit a copy of the completed forms to the WMAP, subject to the adjustments listed below. When you use these forms for non-Medicare clients, you may:

- use forms obtained from the Medicare intermediary and declare them on your Medicare cost report,
- copy or print your own supply of the forms, or
- purchase the forms from another source.

Complete all HCFA forms in accordance with HCFA instructions, subject to the adjustments listed below. These instructions are contained in the Medicare Home Health Agency Manual, Pub. 11 Sec. 234.

Adjustments to HCFA Instructions

HCFA-485

1. Locator 1, Patient's HI Claim No. - Enter the recipient's ten-digit Medical Assistance identification (MA ID) number as shown on the recipient's MA ID card for the current month.

2. Locator 2, SOC Date - For clients receiving services under both Medicare and the WMAP, enter the Medicare start of care date. For WMAP recipients who are not also receiving services under Medicare, enter the date of the first WMAP billable visit.

3. Locator 5, Provider No. - Enter the provider's WMAP provider number.
   Locator 4 14, DME and Supplies - Enter only items ordered by the physician here. List other items used by the recipient on the HCFA 487.

4. Locator 11, Principal Diagnosis - Note that the diagnosis stated here must be the primary reason for going into the home to provide services.

5. Locator 19, Mental Status - Enter the recipient's mental status as determined by the physician or RN. This information must reflect the recipient's ability or inability to direct, instruct, and supervise an unlicensed caregiver in safe provision of health care services. Information may be continued on the HCFA 487.

6. Locator 21, Orders for Discipline and Treatments - *Note that Medicare instructions state that orders must include all disciplines and treatments, even if they are not billable to Medicare.*

   Be sure to provide complete information. PPOCs which do not provide sufficient information to substantiate a prior authorization request are returned.

In addition, the WMAP requires that orders must indicate which health care services/amounts are being furnished by another provider (e.g. "Family members are providing 16 hours of the skilled nursing care" or "The county is providing 8 hours of supportive home care services under COP").

If the services are billable to the WMAP, the name of the other provider must be indicated (e.g. "Acme Home Health Agency is providing the OT visits.")

Identify the total number of hours of skilled nursing care needed by the recipient and note who will be providing.

6. Locator 23, Verbal Start of Care and Nurse's Signature and Date Where Applicable - The registered nurse accepting verbal orders must sign and date here.

7. Locator 26, Cross out any part that does not apply. Explain exceptions to "confined to his home" under Locator 20 and 21 of HCFA 486.

8. Locator 27, Attending Physician's Signature - If the physician's signature is not entered, the registered nurse who has accepted the verbal orders must sign and date the form at Locator 23. The signed HCFA 485 must be placed in the recipient's file within 20 days of the verbal order. Services provided without properly documented physician orders are subject to recoupment.

HCFA-486

1. Locator 1, HIC No. - Enter the recipient's ten-digit Medical Assistance identification (MA ID) number as shown on the recipient's MA ID card for the current month.

2. Locator 13, Specific Services and Treatments - Enter the treatment codes for each discipline. Other informaton at this location are optional.

3. Location 16 - When the delegating nurse must be identified, providers must indicate the delegating registered nurse in this space by entering the nurse's name and that the nurse is delegating (e.g., "Jane Doe, RN, Delegating Nurse").

HCFA-487

1. Locator 1, Patient's HI Claim No. - Enter the recipient's ten-digit Medical Assistance identification (MA ID) number as shown on the recipient's MA ID card for the current month.

2. Locator 2, SOC Date - For dual-entitlees, enter the Medicare start of care date. For WMAP recipients who are not also eligible for Medicare, enter the date of the first WMAP billable visit.

3. Locator 5, Provider No. - Enter the provider's WMAP provider number.

4. Locator 9, Signature of Physician - If the physician's signature is not entered, the registered nurse who has accepted the verbal orders must sign and date the form at Locators 11/12. The signed HCFA 487 must be placed in the recipient's file within 20 days of the verbal order. Services provided without properly documented physician orders are subject to recoupment.

5. Locators 11/12, Optional Name/Signature of Nurse/Therapist - The registered nurse accepting verbal orders must sign and date here.

APPENDIX 6
SAMPLE HCFA FORM 485
PRIVATE DUTY NURSING SERVICES

Department of Health and Human Services
Health Care Financing Administration

Form Approved
OMB No. 0938-0357

HOME HEALTH CERTIFICATION AND PLAN OF TREATMENT

1. Patient's HI Claim No.	2. SOC Date	3. Certification Period	4. Medical Record No.	5. Provider No.
1234567890	mm/dd/yy	From: mm/dd/yy To: mm/dd/yy		12345678

6. Patient's Name and Address
Recipient, Ima A.
609 Willow
Anytown, WI 55555

7. Provider's Name and Address
I.M. Provider
1 W. Williams
Anytown, WI 55555

8. Date of Birth: 01/01/59 **9. Sex** [X] M [ ] F

10. Medications: Dose/Frequency/Route (N)ew (C)hanged
SMZ - TMP DS - BID - g tube
DSS syrup - 10 cc - daily - g tube
Dulcolax suppos - I QOD & PRN - PR
Dulcolax tab. - 2-PRN/constipation-g tube
Fleet enema- 1-PRN/constipation - PR
Vitamin C -500 mg - 1 tab. daily-g tube
triple antibiotic ointment-PPN-topically
Urologic Sol. G for Cath. irrigation-PR

11. ICD-9-CM	Principal Diagnosis	Date
3340	quadraplegia C3-4	mm/dd/yy
12. ICD-9-CM	Surgical Procedure	Date
	n/a	
13. ICD-9-CM	Other Pertinent Diagnoses	Date
599.0	urinary tract infection	mm/dd/yy

14. DME and Supplies
catheter kit, wheelchair, g tube

15. Safety Measures: observe for signs or autonomic dysreflexia; plan for emergencies

16. Nutritional Req. 2500 cal. blendarized food

17. Allergies: none

18.A. Functional Limitations

1 [ ]	Amputation	5 [X]	Paralysis	9 [ ]	Legally Blind
2 [X]	Bowel/Bladder (Incontinence)	6 [X]	Endurance	A [ ]	Dyspnea With Minimal Exertion
3 [X]	Contracture	7 [X]	Ambulation	B [ ]	Other (Specify)
4 [ ]	Hearing	8 [X]	Speech		

18.B. Activities Permitted

1 [ ]	Complete Bedrest	6 [ ]	Partial Weight Bearing	A [ ]	Wheelchair
2 [ ]	Bedrest BRP	7 [ ]	Independent At Home	B [ ]	Walker
3 [X]	Up As Tolerated	8 [ ]	Crutches	C [ ]	No Restrictions
4 [X]	Transfer Bed/Chair	9 [ ]	Cane	D [X]	Other (Specify) sip & puff control
5 [X]	Exercises Prescribed				

19. Mental Status:							
1 [X]	Oriented	3 [ ]	Forgetful	5 [ ]	Disoriented	7 [ ]	Agitated
2 [ ]	Comatose	4 [ ]	Depressed	6 [ ]	Lethargic	8 [ ]	Other

20. Prognosis:									
1 [ ]	Poor	2 [X]	Guarded	3 [ ]	Fair	4 [ ]	Good	5 [ ]	Excellent

21. Orders for Discipline and Treatments (Specify Amount/Frequency/Duration)
RN- 24 hrs/day X 7 days/week X 6 mos.
(12 hrs/day under the WMAP, 12 hrs/day provided by brother-at night. The brother is working during the day & is still learning about the care needed.)

[Alternate method of indicating orders: 12 hrs/day provided by this agency
12 hrs/day provided by brother
24 hrs/day total]

Duties include: trach. care q 8 hrs.; suction q hr. or PRN; ADL care; up in wheelchair q shift; irrigate catheter when obstructed; catheter care q shift; observe skin for pressure areas or redness; assess pulmonary status; gastrostomy tube feeding q 4 hrs.; liquids periodically; passive range of motion q shift; repositioning q 2 hrs and PRN; meds. as prescribed.

22. Goals/Rehabilitation Potential/Discharge Plans It is anticipated that this is a lifelong need; however, the brother may assume more care as he becomes more comfortable & knowledgable about the care. Goal is to decrease urinary tract infections and decubiti, keep patient out of hospital, and encourage self-direction in all cares.

23. Verbal Start of Care and Nurse's Signature and Date Where Applicable: n/a

24. Physician's Name and Address
I.M. Physician
1 Jones Street
Anytown, WI 55555

25. Date HHA Received Signed POT
mm/dd/yy

26. I [X] certify [ ] recertify that the above home health services are required and are authorized by me with a written plan for treatment which will be periodically reviewed by me. This patient is under my care, is confined to his home, and is in need of intermittent skilled nursing care and/or physical or speech therapy or has been furnished home health services based on such a need and no longer has a need for such care or therapy, but continues to need occupational therapy.

27. Attending Physician's Signature (Required on 485 Kept on File in Medical Records of HHA)
I. M. Physician, M.D.

Date Signed
mm/dd/yy

Form HCFA-485 (C4) (4-87)

APPENDIX 6a
SAMPLE HCFA FORM 485
HOME HEALTH

Department of Health and Human Services
Health Care Financing Administration

Form Approved
OMB No. 0938-0357

HOME HEALTH CERTIFICATION AND PLAN OF TREATMENT

1. Patient's HI Claim No.	2. SOC Date	3. Certification Period	4. Medical Record No.	5. Provider No.
1234567890	8/28/91	From: 8/28/91 To: 10/26/91		12345678

6. Patient's Name and Address
Recipient, Ima A.
609 Willow
Anytown, WI 55555

7. Provider's Name and Address.
I.M. Provider
1 W. Williams
Anytown, WI 55555

8. Date of Birth: 8/23/25 **9. Sex** [ ] M [X] F

10. Medications: Dose/Frequency/Route (N)ew (C)hanged
Vasotec - 10 mg - BID - PO
Furosemide - 40 mg - BID - PO
Digoxin -.25 mg - QOD - PO
Lozol - 2.5 mg - BID - PO
Tetracycline - 250 mg -daily - PO
Hydroxyzine - 10 mg - QHS - PO
Ferrous Gluconate - 5 gr - BID - PO
MOM - 30 cc - PRN for constipation

11. ICD-9-CM	Principal Diagnosis	Date
401.9	Hypertension NOS	1/1/85
12. ICD-9-CM	**Surgical Procedure**	**Date**
	n/a	
13. ICD-9-CM	**Other Pertinent Diagnoses**	**Date**
250.00	Diabetes Type II(NIDDM)	2/1/90
251.2	Hypoglycemia NOS	8/28/91
599.0	Urinary Tract Infection NOS	8/28/91

14. DME and Supplies
glucometer, rolling walker,bedside commode.

15. Safety Measures:
change positions slowly

16. Nutritional Req. 1400 calore diabetic, NAS

17. Allergies: none

18.A. Functional Limitations

1	[ ]	Amputation	5	[ ]	Paralysis	9	[ ]	Legally Blind			
2	[ ]	Bowel/Bladder (Incontinence)	6	[X]	Endurance	A	[ ]	Dyspnea With Minimal Exertion			
3	[ ]	Contracture	7	[X]	Ambulation	B	[ ]	Other (Specify)			
4	[ ]	Hearing	8	[ ]	Speech						

18.B. Activities Permitted

1	[ ]	Complete Bedrest	6	[ ]	Partial Weight Bearing	A	[ ]	Wheelchair			
2	[ ]	Bedrest BRP	7	[ ]	Independent At Home	B	[ ]	Walker			
3	[X]	Up As Tolerated	8	[ ]	Crutches	C	[ ]	No Restrictions			
4	[ ]	Transfer Bed/Chair	9	[ ]	Cane	D	[ ]	Other (Specify)			
5	[ ]	Exercises Prescribed									

19. Mental Status:

1	[X]	Oriented	3	[X]	Forgetful	5	[ ]	Disoriented	7	[ ]	Agitated
2	[ ]	Comatose	4	[ ]	Depressed	6	[X]	Lethargic	8	[ ]	Other

20. Prognosis:

1	[ ]	Poor	2	[X]	Guarded	3	[ ]	Fair	4	[ ]	Good	5	[ ]	Excellent
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21. Orders for Discipline and Treatments (Specify Amount/Frequency/Duration)

RN - 1 visit PRN/mo. x 6 months - if condition changes, such as when blood pressure or glucose becomes unstable and exceed parameters established for patient (WMAP)

HHA - 2 x wk for 2 hrs per visit x 6 mos - assist with ADLs and ambulation, foot soak each visit & report any color, temp., sensation, or skin abnormalities to RN immediately. HHA not to trim toenails. Take & record blood pressure in both arms & report to RN q visit. Vital signs q visit. Meal planning & preparation of 1400 calorie ADA diet. HHA to observe for s/s of low or high blood glucose & report any changes to RN. (WMAP)

Family members will assist with medications. Daughter will also check the blood glucose levels 2 x week and report to the RN.

22. Goals/Rehabilitation Potential/Discharge Plans Patient will continue to follow 1400 cal. ADA diet & maintain blood glucose within normal limits. Patient will continue to receive assistance with ADLs, bath, & meal prep., as needed. Patient will progress to her max potential with ADLs & ambulation. Patient will have blood pressure monitored 2x wk. Patient will continue to receive family support.

23. Verbal Start of Care and Nurse's Signature and Date Where Applicable: 8/26/91

24. Physician's Name and Address
I.M. Physician
1 Jones Street
Anytown, WI 55555

25. Date HHA Received Signed POT
9/1/91

26. I [X] certify [ ] recertify that the above home health services are required and are authorized by me with a written plan for treatment which will be periodically reviewed by me. This patient is under my care, ~~is confined to his home,~~ and is in need of intermittent skilled nursing care and/or physical or speech therapy or has been furnished home health services based on such a need and no longer has a need for such care or therapy, but continues to need occupational therapy.

27. Attending Physician's Signature (Required on 485 Kept on File in Medical Records of HHA)
I. M. Physician, M.D.

Date Signed
8/28/91

Form HCFA-485 (C4) (4-87)

APPENDIX 7
SAMPLE HCFA FORM 486

Department of Health and Human Services
Health Care Financing Administration

Form Approved
OMB No. 0938-0357

MEDICAL UPDATE AND PATIENT INFORMATION

1. Patient's HI Claim No.	2. SOC Date	3. Certification Period	4. Medical Record No.	5. Provider No.
1234567890	MM/DD/YY	From: 041492 To: 050592		87654321

6. Patient's Name: Recipient, Ima A.

7. Provider's Name: I.M. Provider

8. Medicare Covered: ☐ Y ☒ N

9. Date Physician Last Saw Patient:

10. Date Last Contacted Physician: 041492

11. Is the Patient Receiving Care in an 1861 (J)(1) Skilled Nursing Facility or Equivalent? ☐ Y ☒ N ☐ Do Not Know

12. ☐ Certification ☐ Recertification ☒ Modified

13. Specific Services and Treatments

Discipline	Visits (This Bill) Rel. to Prior Cert.	Frequency and Duration	Treatment Codes	Total Visits Projected This Cert.
HHN			A1, A6, A12, A27	

14. Dates of Last Inpatient Stay: Admission 021592 Discharge 030592

15. Type of Facility: acute hospital

16. Updated Information: New Orders/Treatments/Clinical Facts/Summary from Each Discipline

Daily v for 3 days to assess condition.
If stable, reduce to 1v/day x 3 days/week.
If still stable, return to 2 visits/week.

Skilled nursing PRN visit on 04/14/92 for FBS. Chemstrip was over 400. Physician made house-call on 04/14/92 for episode of hyperglycemia and changed orders per above. PT on hold until glucose stabilized.

17. Functional Limitations (Expand From 485 and Level of ADL) Reason Homebound/Prior Functional Status

18. Supplementary Plan of Treatment on File from Physician Other than Referring Physician: ☐ Y ☐ N
(If Yes, Please Specify Giving Goals/Rehab. Potential/Discharge Plan)

19. Unusual Home/Social Environment

20. Indicate Any Time When the Home Health Agency Made a Visit and Patient was Not Home and Reason Why if Ascertainable

21. Specify Any Known Medical and/or Non-Medical Reasons the Patient Regularly Leaves Home and Frequency of Occurrence

1484/3

22. Nurse or Therapist Completing or Reviewing Form: L. M. Nurse, RN. (verbal orders from L. M. Physician) Date (Mo., Day, Yr.): MM/DD/YY

Form HCFA-486 (C3) (4-87) PROVIDER

APPENDIX 8
SAMPLE HCFA FORM 487

Department of Health and Human Services
Health Care Financing Administration

Form Approved
OMB No. 0938-0357

ADDENDUM TO: ☐ **PLAN OF TREATMENT** ☐ **MEDICAL UPDATE**

1. Patient's HI Claim No.	2. SOC Date	3. Certification Period From: To:	4. Medical Record No.	5. Provider No.

6. Patient's Name	7. Provider Name

8. Item No.	

9. Signature of Physician	10. Date

11. Optional Name/Signature of Nurse/Therapist	12. Date

Form HCFA-487 (C4) (4-87)